TRICARE PRIME ENROLLMENT APPLICATION AND PRIMARY CARE MANAGER (PCM) CHANGE FORM

(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)

SECTION I - SPONSOR INFORMATION

X one:

	Prime Enrollment		Prime Remote Enrollment		US Family Health Plan Enrollment		PCM Change		Transfer Enrollment		Split Enrollment

1. SPONSOR IS: *(X one)*

	Active Duty		Retired		Deceased *(Go to Section II.)*		Former Spouse

2. SPONSOR SOCIAL SECURITY NUMBER (SSN)	3. SPONSOR NAME *(Last, First, Middle Initial)* *(Must match DEERS)*	4. SPONSOR DATE OF BIRTH *(YYYYMMDD)*
___ ___ ___ - ___ ___ - ___ ___ ___ ___		

5. RESIDENCE ADDRESS

a. STREET	b. APARTMENT/ SUITE NO.	c. CITY	d. STATE	e. ZIP CODE

6. MAILING ADDRESS *(If different from residence address)*

a. STREET	b. APARTMENT/ SUITE NO.	c. CITY	d. STATE	e. ZIP CODE

7. SPONSOR TELEPHONE NUMBERS *(Include Area Code)*		8. CITY AND COUNTRY OF MILITARY ASSIGNMENT *(OCONUS only)*
a. HOME ( )	b. WORK ( )	

9. MEMBER'S UNIT	10. UNIT IDENTIFICATION CODE (UIC) *(If known)*	11. ZIP CODE OF WORK ADDRESS	12. E-MAIL ADDRESS

13. SPONSOR PRIMARY CARE PCM PREFERENCE *(Honoring your preference depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF, or US Family Health Plan Member Services for availability of PCMs.) (Complete all that apply.)*

a. PCM FULL NAME, MTF/CLINIC ADDRESS *(If known)*	1st CHOICE	
		MTF
		Other
	2nd CHOICE	
		MTF
		Other

b. PCM SPECIALTY		No Preference		Flight Medicine			
		Family/General Practice		Internal Medicine			
c. PREFERRED PCM GENDER		No Preference		Male		Female	

SPONSOR SOCIAL SECURITY NUMBER — —	SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*

SECTION II - ENROLLING FAMILY MEMBER INFORMATION OR PCM CHANGE

(Use additional copies of this page to continue as necessary)

1.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*	b. DATE OF BIRTH *(YYYYMMDD)*

c. RESIDENCE ADDRESS ☐ Same as Sponsor				
(1) STREET	(2) APARTMENT/ SUITE NO.	(3) CITY	(4) STATE	(5) ZIP CODE

d. MAILING ADDRESS *(If different from residence address)* ☐ Same as Sponsor				
(1) STREET	(2) APARTMENT/ SUITE NO.	(3) CITY	(4) STATE	(5) ZIP CODE

e. RELATIONSHIP TO SPONSOR	f. TELEPHONE NUMBERS *(Include Area Code) (If different from sponsor)*		g. E-MAIL ADDRESS
☐ Spouse ☐ Child	(1) HOME ( )	(2) WORK ( )	

h. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.) (Complete all that apply.)*

(1) PCM FULL NAME MTF/CLINIC ADDRESS *(If known)*	1st CHOICE	☐ Same as Sponsor ☐ MTF ☐ Other
	2nd CHOICE	☐ Same as Sponsor ☐ MTF ☐ Other

(2) PCM SPECIALTY	☐ No Preference	☐ Flight Medicine	☐ Pediatrics	☐ Family/General Practice	☐ Internal Medicine
(3) PREFERRED PCM GENDER	☐ No Preference		☐ Male	☐ Female	

2.a. FAMILY MEMBER NAME *(Last, First, Middle Initial) (Must match DEERS)*	b. DATE OF BIRTH *(YYYYMMDD)*

c. RESIDENCE ADDRESS ☐ Same as Sponsor				
(1) STREET	(2) APARTMENT/ SUITE NO.	(3) CITY	(4) STATE	(5) ZIP CODE

d. MAILING ADDRESS *(If different from residence address)* ☐ Same as Sponsor				
(1) STREET	(2) APARTMENT/ SUITE NO.	(3) CITY	(4) STATE	(5) ZIP CODE

e. RELATIONSHIP TO SPONSOR	f. TELEPHONE NUMBERS *(Include Area Code) (If different from*		g. E-MAIL ADDRESS
☐ Spouse ☐ Child	(1) HOME ( )	(2) WORK ( )	

h. PRIMARY CARE MANAGER (PCM) PREFERENCE *(Honoring your preferences depends upon availability and local MTF policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member service for availability of PCMs.) (Complete all that apply.)*

(1) PCM FULL NAME MTF/CLINIC ADDRESS *(If known)*	1st CHOICE	☐ Same as Sponsor ☐ MTF ☐ Other
	2nd CHOICE	☐ Same as Sponsor ☐ MTF ☐ Other

(2) PCM SPECIALTY	☐ No Preference	☐ Flight Medicine	☐ Pediatrics	☐ Family/General Practice	☐ Internal Medicine
(3) PREFERRED PCM GENDER	☐ No Preference		☐ Male	☐ Female	

SPONSOR SOCIAL SECURITY NUMBER	SPONSOR NAME *(Last, First, Middle Initial) (Must match DEERS)*
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SECTION III - OTHER HEALTH INSURANCE

1. ARE ANY ENROLLING FAMILY MEMBERS OR IS THE RETIREE CURRENTLY COVERED BY OTHER HEALTH INSURANCE *(not a TRICARE Supplement)*? If Yes, provide the name of the family member and other health insurance, policy number, effective dates, and a copy of the other health insurance policy and their insurance card.	☐	Yes
	☐	No
2. IS THE RETIREE OR ARE ANY RETIREE FAMILY MEMBERS UNDER AGE 65 AND ELIGIBLE FOR MEDICARE BASED ON DISABILITY OR END STAGE RENAL DISEASE? If Yes, provide a copy of the Medicare card for each family member that is under the age of 65 and entitled to Medicare.	☐	Yes
	☐	No

SECTION IV - REASON FOR PCM CHANGE

1. NAME OF AFFECTED FAMILY MEMBER(S)	2. REASON FOR CHANGE *(X as applicable. If more than one family member and reason, specify.)*
	☐ Dissatisfied ☐ Permanent Change of Station (PCS) ☐ Relocation
	☐ Other *(Use Section II to specify change of PCM specialty/ gender preference for more than one family member.)*

SECTION V - ACCESS WAIVER

Please read and sign if you are outside the service area.

By signing this application, you indicate your understanding and acceptance that your travel time to the network of primary care delivery sites may exceed 30 minutes from your home to the delivery site and your travel time for specialty care may exceed one hour.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED *(YYYYMMDD)*

SECTION VI - SIGNATURE

I understand that it is my responsibility to comply with all TRICARE Prime procedures. By signing the form, I certify that the information on this form is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments or concealment of a material fact may be subject to fine and imprisonment under applicable Federal law.

1. SIGNATURE OF SPONSOR, SPOUSE, OR OTHER LEGAL GUARDIAN OF BENEFICIARY	2. RELATIONSHIP TO SPONSOR	3. DATE SIGNED *(YYYYMMDD)*